PLEASE DO NOT STAPLE IN THIS AREA						°FQHC/RHC °Immuniza	tions Only						
PICA						HEALTH IN	SURANCE C	:1 A1	M FC	)RM			PICA
	DICAID C	HAMPUS	S	CHAMPVA	GROUP	FECA OTHE	R 1a. INSURED'S I.D.				(FOR	PROGRAM	
. X		ponsor's		(VA File #)		BLK LUNG (ID)	900000000	3					
2. PATIENT'S NAME (Last	Name, First Nam	e, Middle	Initial)	1	3 PATIENT'S BIRTH DAT MM DD YY 05 29 199	E SEX	4. INSURED'S NAME	E (Last I	lame, Fi	rst Name	e, Middle	le Initial)	
5. PATIENT'S ADDRESS (F	No Street				05 29 199 6. PATIENT RELATIONSH	6 <sup>M</sup> X F	7 110 105010 100						
				[		Child Other	7. INSURED'S ADDE	RESS (N	o., Stree	t)			
22 Masters Ian	Е			STATE 8	B. PATIENT STATUS	Name of the state	CITY					s	TATE
Raleigh				NC	Single Marrie	d Other						- 1	
ZIP CODE			ude Area C		Employed Full-Tim		ZIP CODE		TE	LEPHO	NE (INC	CLUDE AREA	CODE
9. OTHER INSURED'S NAM		,	5-1212 e Middle In		Student 10. IS PATIENT'S CONDIT	Student	11. INSURED'S POL	ICV OF	DUB OC	(	)		
S. STREET INSURED S NAM	нь (саж наше, г	or Maine	o, middle In		IS IS FATIENT S CONDIT	HOW RECEIVED TO:	I I INSURED'S POLI	ICY GAI	JUP OR	reca N	NUMBER	н	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				ē	a. EMPLOYMENT? (CURR	a. INSURED'S DATE OF BIRTH SEX							
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F				t	AUTO ACCIDENT?	b. EMPLOYER'S NAM	ME OR S	SCHOOL					
C. EMPLOYER'S NAME OR SCHOOL NAME				·	OTHER ACCIDENT?	NO	c. INSURANCE PLAN	NAME	OR PRO	GRAM	NAME	,	
d. INSURANCE PLAN NAMI	E OR PROGRAM	NAME		1	0d. RESERVED FOR LOC	AL USE	d. IS THERE ANOTH	ER HEA	LTH BEI	NEFIT P	LAN?		
R	EAD BACK OF	ORM BE	FORE CO	MPLETING A	SIGNING THIS FORM.		13. INSURED'S OR A	NO				complete iten	
12. PATIENT'S OR AUTHOR	RIZED PERSON	S SIGNA	TURE I au	thorize the rel	ease of any medical or othe	r information necessary accepts assignment	payment of medica services described	al benefi					
to process this claim. I also below.	so request payme	nt or gove			mysell of to the party who a								
to process this claim. I all below.	so request payme				DATE		SIGNED						
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